



Iowa Medicaid HCBS Waiver Provider Application

Basic Information

To avoid delays in the enrollment process, you should:

- Complete all required forms listed below.
- If extra space is needed to answer any questions, please attach any additional pages.
- Type or print all information so that it is legible. Do not use a pencil.
- If any field is not applicable, please enter N/A.
- An incomplete form will delay the approval process.
- Attach all required supporting documentation.
- Make sure you read the instructions before completing the application.

Mail completed application and all applicable attachments to:

Iowa Medicaid Enterprise
Provider Services
P.O. Box 36450
Des Moines, IA 50315

For questions contact:

Provider Services, Enrollment:
Tel. (800) 338-7909 option 2 or
(515) 256-4609 option 2 (local)

Individual applicants applying to provide Consumer-Directed Attendant Care (CDAC) must complete and submit the following forms:

- Form 470-2917 - Medicaid HCBS Waiver Provider Application (Sections: I and II)
- Form 470-2965 - Provider Agreement
- Form 470-4202 - EFT
- IRS Form W9
- Form 470-4612 - Individual CDAC Disclosure
- Form 470-4457 - Atypical Provider Declaration
- Form 470-4227 - Record Check Consent
- Proof of age (copy of driver's license, birth certificate, state issued ID, passport)

Agencies and businesses applying for waiver services must complete the following forms:

If you are enrolling in the Medicaid program for the first time or already enrolled, but you have a new Tax Identification Number, the following forms are required:

- Form 470-2917 - Medicaid HCBS Waiver Provider Application (Sections: I and III)
- Form 470-2965 - Provider Agreement
- Form 470-4202 - EFT
- IRS Form W-9
- Form 470-5112 - Designated Contract Person

Agencies adding on waiver services:

If you are already enrolled and active, to add services to your existing enrollment the following form is required:

- Form 470-2917 - Medicaid HCBS Waiver Provider Application (Sections: I and III)

Instructions for Completing the Iowa Department of Human Services Iowa Medicaid HCBS Waiver Provider Enrollment Application

Reason for Application: Check one box.

I. General Section

- 1 **National Provider Identifier (NPI)** – Complete this section **only** if you are a current Iowa Medicaid Provider. Enter the NPI for the provider. If you do not have an NPI, enter your ten-digit Iowa Medicaid Provider number (beginning with “X00....”).
- 2-7 Enter the location information for the provider.
- 8-9 **County Name and Number** – Enter the name and number of the county of residence (if out of state – enter the name and number of the county served).
- 10 **Telephone Number** – Enter area code and phone number.
- 11 **Cellular Telephone Number** – Enter area code and phone number, if available.
- 12 **Fax** – Enter area code and fax number, if available.
- 13 **Email Address** – Enter email address, if available. By providing your email address, you agree that we may communicate with you by electronic mail.
- 14 **Desired Effective Date for Enrollment** – This date cannot be retroactive before the first of the month in which the application is approved. Providers cannot bill or be paid for service provided prior to the Department of Human Services (DHS) approval of the service enrollment.
- 15 **Leave Blank** (For Future Use).

II. Individual applicants applying for Consumer-Directed Attendant Care (CDAC)

If you are applying on behalf of an agency, proceed to section III.

If you are an **individual** applying for services other than Consumer-Directed Attendant Care, proceed to Section III. (**This is not common.**)

- 16 **Social Security Number** – Enter your social security number here.
- 17 **Check each box that applies:**
 - ☐ – CDAC waiver types include: Health and Disability (H&D), AIDS/HIV (AH), Elderly (E), Intellectual Disability (ID), and Physical Disability (PD).
 - Individuals approved to provide CDAC waiver services will be enrolled in: ID, AH, E, ID, and PD.
 - Individuals who apply to provide CDAC waiver services are required to submit proof of age and must send in a copy of either a birth certificate **or** a driver's license. The date of birth must be clearly legible or it will not be accepted.
 - ☐ – Brain Injury Waiver
 - Additional documentation is required for those wishing to provide Brain Injury Waiver services.

Note: The CDAC provider cannot bill or be paid for service provided prior to DHS written approval of this service. That is indicated by the case manager or DHS service worker attaching the *HCBS Consumer-Directed Attendant Care Agreement*, form 470-3372, to the service plan in the AIDS/HIV, Brain Injury, Elderly, Health and Disability, Intellectual Disability, and Physical Disability waivers. No payments will be made prior to the case manager's or DHS service worker's written approval of this service.

18-19 **Signature** – Original signature required. **Date** – Enter the date application is signed.

III. Agencies and businesses applying for waiver services

16 **Tax ID Number** – Enter your Internal Revenue Service (IRS) Tax ID number.

17 **Taxonomy code** – Enter the taxonomy code.

18-20 **Self-explanatory.**

21 Check Yes or No if you are enrolled in another state's Medicaid or CHIP program. If yes, please list the states and the program.

22 Check Yes or No if you are enrolled in Medicare.

23 Type of Ownership - check one.

24 Indicate which services you are applying for by checking the box next to that service. Under the service you are applying for check **one** of the standards that qualify you or your agency to provide that service. Next to the standard, circle the waiver type for which you are applying. Include with the application the documentation supporting the specific requirement that qualifies you or your agency to provide the service.

25 **Signature** – Original signature required. Applications not properly signed will be returned.

26 **Date** – Enter date application is signed. Applications not dated will be returned.

27 **Contact Person** – Enter the name of the person who should be contacted for questions regarding the application.

NOTE: Those wishing to provide services under the Brain Injury Waiver need to submit documentation indicating training or experience working with persons with an identified brain injury. The following services are exempt from the Brain Injury Waiver training requirement: Home or Vehicle Modification (HVM), Specialized Medical Equipment (SME), Personal Emergency Response (PERS), and Transportation.

Form 470-4547 is required when enrolling for services that require submission of a complete Provider Quality Management Self-Assessment and/or submission of policies, procedures and forms.

Once the application process has been approved, you will receive notification from the Iowa Medicaid Enterprise (IME).

Iowa Medicaid HCBS Waiver Provider Application

Individual applicants applying to provide Consumer-Directed Attendant Care (CDAC) should complete sections I and II. Agencies and businesses applying to provide waiver services should complete sections I and III.

I. GENERAL SECTION

Reason for Application: Check one box.

<input type="checkbox"/> You are a NEW enrollee in Iowa Medicaid (the Tax Identification or Social Security Number has not been enrolled in Medicaid)	<input type="checkbox"/> You are REACTIVATING your Iowa Medicaid provider number	<input type="checkbox"/> You are CHANGING to a new Tax Identification Number (if you are already enrolled, but have a new Tax Identification Number)	<input type="checkbox"/> You are ADDING-ON additional services to an existing enrolled Iowa Medicaid provider
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1. National Provider Identifier (NPI) (if you are not currently a Medicaid provider, leave blank)																			
2. Provider Name																			
3. Mailing Address																			
4. Street Address (if different from the mailing address)																			
5. City															6. State				
7. Zip Code (please enter 9-digit zip code, if known)																			
8. County Name																9. County Number			
10. Telephone Number (daytime)								()							
11. Cellular Telephone Number (optional)								()							
12. Fax Number (if available)								()							
13. Email Address (please, print)																			
14. Desired Effective Date for Enrollment (MM/DD/YYYY) (THIS DATE WILL NOT BE RETROACTIVE BEFORE THE FIRST OF THE MONTH IN WHICH THE APPLICATION IS <u>APPROVED</u>)												/			/				
15. Leave Blank (For Future Use)																			

If you are an individual applying for Consumer-Directed Attendant Care (CDAC), please proceed to section II, otherwise proceed to section III.

II. Application for Individual Consumer-Directed Attendant Care

16. Social Security Number

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Service and Requirements

17. Check the box(es) below for each HCBS Waiver program for which application is being made:

☐ — Consumer-Directed Attendant Care (CDAC) waiver types include: H&D, AH, E, ID and PD.

- Individual Applicant (Attach a photocopy of birth certificate or driver's license. The document must show name and date of birth.)

☐ — Brain Injury Waiver waiver type is: BI

Those wishing to provide CDAC services under the Brain Injury Waiver must submit documentation indicating training or experience working with persons with an identified brain injury.

To demonstrate that you meet the criteria to be enrolled as a Brain Injury Waiver provider, please submit one or more of the following:

- Training certificates;
- Credentials (Brain injury specialist, RN, LPN, OT, PT, CNA license);
- Resumé including a detailed description of job duties and employment start and end dates;
- A signed and dated personal statement from the applicant detailing experience with working hands on direct care with persons with a brain injury diagnosis;
- A signed and dated personal statement that you reside in the household of the member, and/or are the parent of the member who will be receiving the CDAC services and demonstrate that you have provided instruction on the care of the individual member or a brain injury professional;
- A signed and dated personal statement that you been providing direct care to a person with a brain injury. List the types of assistance and support you have provided and the length of time that you have been providing those services;
- Online training available at: <https://secureapp.dhs.state.ia.us/lowatbi/> this course, or equivalent, is required for HCBS/BI waiver service provision.

Upon receipt of the documentation, it will be reviewed for approval. If the documentation is found to be insufficient, you will be required to take an approved training for individuals with a brain injury. You cannot become a Brain Injury Waiver provider without attending training or having the training waived through your experience and outside training.

Read and sign the following statement:

As a Medicaid provider of consumer-directed attendant care services:

- I understand that if I am the parent or stepparent of a consumer aged 17 or under, or the spouse of a consumer, that I may not provide services to those individuals.
- I understand that I may not provide consumer-directed attendant care services for a consumer for whom I am a caretaker and for whom I am the beneficiary of respite services that are funded by an HCBS waiver.
- I understand that all consumer-directed attendant care service activities are supportive. I must be qualified by prior training and/or experience and/or a certificate of formal training to carry out the consumer's plan of care pursuant to the department approved service plan.
- I understand that I must describe in detail my training and/or experience on form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*, and this will be reviewed and approved by the Medicaid case manager or service worker for appropriateness of training and/or experience prior to provision of services. Form 470-3372 becomes an attachment to and a part of the service plan. I will receive direction and training from consumers for activities to maintain independence that are not medical in nature. I will receive from licensed nurses and therapists on-the-job training and supervision for skilled activities described on form 470-3372. All training and experience must be sufficient to protect the health, welfare, and safety of the consumer.
- I have made a copy of this application for my own records.

STATEMENT

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION IN, OR RELATED TO, THIS APPLICATION MAY BE PUNISHABLE BY CRIMINAL, CIVIL (INCLUDING A FALSE CLAIMS LAWSUIT) AND/OR ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.

CERTIFICATION

I HEREBY CERTIFY that I have read the above statement, and that I have examined this application and all accompanying documents, and that to the best of my knowledge and belief, each is true, correct, and complete. I further certify that I am familiar with the laws and regulations governing the medical assistance program (Iowa Medicaid) and that I am duly qualified to participate as a provider in that program. I PROMISE to apprise Iowa Medicaid immediately of any material changes to this application and provide true, correct, and complete answers to any subsequent questions of me by Iowa Medicaid related to or arising out of this application.

18. Signature

19. Date

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III. Agencies and Businesses applying for waiver services

16. Tax ID Number			—						
17. Taxonomy code									
18. Has the provider ever been sanctioned by Medicaid, Medicare or other state health program?									<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Has there been any disciplinary action against you by any licensing boards, accrediting or certification body?									<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Have you ever been excluded from participation in the Medicaid or Medicare Program? If "yes," please explain on a separate piece of paper.									<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Are you currently enrolled in another state's Medicaid/Chip program? <input type="checkbox"/> Yes – please list the state and what program <input type="checkbox"/> No					22. Are you currently enrolled with Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No				
23. Type of Ownership Code (Check One) <div style="display: flex; flex-wrap: wrap; padding: 5px;"> <div style="width: 33%;"><input type="checkbox"/> Individual Applicant</div> <div style="width: 33%;"><input type="checkbox"/> Partnership</div> <div style="width: 33%;"><input type="checkbox"/> Nonprofit Organization</div> <div style="width: 33%;"><input type="checkbox"/> Limited Partnership</div> <div style="width: 33%;"><input type="checkbox"/> Corporation</div> <div style="width: 33%;"><input type="checkbox"/> Limited Liability Company (LLC)</div> <div style="width: 33%;"><input type="checkbox"/> Sole Ownership</div> <div style="width: 33%;"><input type="checkbox"/> Cooperative</div> </div>									

24. Indicate the service(s) for which you are applying and attach proof that the requirement is met.	
Service and Requirements	Circle the waiver(s) for which you are applying
<input type="checkbox"/> Adult Day Care (ADC)	
<input type="checkbox"/> 70 – Certificate for Adult Day services issued by the Department of Inspections and Appeals confirming that the applicant is in compliance with the standards for adult day services programs adopted by the Department on Aging (attach a copy of the certificate) Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures and forms	→ HD AH E ID BI
<input type="checkbox"/> Assistive Devices (AD)	
<input type="checkbox"/> 61 – Area Agency on Aging as designated in IAC 321 4.4(231) (no supporting documentation required)	→ E
<input type="checkbox"/> 39 – Community Business (attach current proof of liability and workers compensation coverage)	→ E
<input type="checkbox"/> 60 – Provider that were enrolled as assistive device providers as of June 30, 2010, based on a contract or letter of approval from an area agency on aging (attach a copy of the letter)	→ E
<input type="checkbox"/> 06 – Medical equipment and supply dealers (enter your Medicaid Provider # (NPI) _____)	→ E

<input type="checkbox"/> Behavioral Programming (BP)			
<input type="checkbox"/> 17 – Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441-24, Divisions I and III	→	BI	MFP
<input type="checkbox"/> 18 – Agencies which are licensed as meeting the hospice standards and requirements set forth in Department of Inspections and Appeals rules 481-53 or which are certified to meet the standards under the Medicare program for hospice programs	→	BI	MFP
<input type="checkbox"/> 19 – Agencies which are accredited under the mental health service provider standards established by the Mental Health and Disabilities Commission, set forth in 441-24, Divisions I and IV	→	BI	MFP
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→	BI	MFP
<input type="checkbox"/> 20 – Brain injury waiver providers certified pursuant to rule 441-77.39(249A)	→	BI	MFP
<input type="checkbox"/> 93 – Provider certified under HCBS BI Behavior Programming (no supporting documentation required)	→		MFP
<input type="checkbox"/> 94 – A licensed psychologist or psychiatrist (attach a copy of the license)	→		MFP
<input type="checkbox"/> 95 – A behavioral analyst certified by the Behavior Analyst Certification Board (attach certification)	→		MFP
<input type="checkbox"/> 96 – A licensed mental health counselor (attach a copy of the license)	→		MFP
<input type="checkbox"/> 97 – A licensed social worker (attach a copy of the license)	→		MFP
<input type="checkbox"/> 98 – A licensed advanced registered nurse registered as certified in psychiatric mental health (attach license and certification)	→		MFP
Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures and forms			
<input type="checkbox"/> Case Management (CM)			
<input type="checkbox"/> 47 – Meets 441 IAC-24 Case Management (enter your case management # _____)	→	E	BI
<input type="checkbox"/> 86 – An agency or individual that is accredited through the Commission on Accreditation of Rehabilitation Facilities for case management services (attach current certification and most recent CARF survey report)	→	E	
<input type="checkbox"/> 87 – An agency or individual that is accredited through the Council on Quality and Leadership (attach current certification and most recent survey report)	→	E	
<input type="checkbox"/> 88 – An agency or individual that is accredited through Joint Commission on Accreditation of Health Care Organizations (attach current certification and most recent survey report)	→	E	
<input type="checkbox"/> 89 – An agency or individual that meets Iowa Administrative Code 321 Chapter 21 for case management services and is approved by the Department of Aging (must submit a letter from Department of Aging that the requirements are met)	→	E	
<input type="checkbox"/> 90 – An agency or individual that meets Iowa Administrative Department of Public Health in the counties that provide case management according to IAC 641-80.6(1) and has a current contract with the Iowa Department of Public Health	→	E	
Elderly Waiver requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures and forms			
<input type="checkbox"/> Chore			
<input type="checkbox"/> 39 – Community Business (attach current proof of liability and workers compensation coverage)	→	E	
<input type="checkbox"/> 63 – Provider that was enrolled as chore providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging (attach a copy of the letter)	→	E	
<input type="checkbox"/> 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	E	
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→	E	
<input type="checkbox"/> 09 – Agencies authorized to provide similar services through a contract with the Department of Public Health (IDPH) for public health services (enter your contract # _____)	→	E	
<input type="checkbox"/> 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	E	

<input type="checkbox"/> Consumer Directed Attendant Care (CDAC)		
Agency		
<input type="checkbox"/> 09 – Agencies authorized to provide similar services through a contract with the Department of Public Health (IDPH) for public health services (enter your contract # _____)	→	HD AH E ID BI PD
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→	HD AH E ID BI PD
<input type="checkbox"/> 13 – Chore provider subcontracting with an area agency on aging (attach a copy of the contract)	→	HD AH E ID BI PD
<input type="checkbox"/> 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	HD AH E ID BI PD
<input type="checkbox"/> 15 – Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	→	HD AH E ID BI PD
<input type="checkbox"/> 16 – Assisted Living Program accredited/certified by Department of Inspections and Appeals as designated in IAC 481-69 (Requires submission of a completed Provider Quality Management Self-Assessment)	→	HD AH E ID BI PD
<input type="checkbox"/> 83 – Provider with a certificate for Adult Day Services issued by the Department of Inspections and Appeals confirming that the applicant is in compliance with standards for adult day services programs adopted by the Department on Aging (attach a copy of the certificate)	→	HD AH E ID BI PD
Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures and forms		
<input type="checkbox"/> Assisted Living (On Call)		
<input type="checkbox"/> 16 – Assisted Living Program accredited/certified by Department of Inspections and Appeals as designated in IAC 481-69 (attach a copy of the certificate)	→	E
<input type="checkbox"/> Counseling (Couns)		
<input type="checkbox"/> 22 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation _____)	→	HD AH
<input type="checkbox"/> 23 – Hospice (attach a copy of the license or enter you Certificate of License or Medicare Provider # _____)	→	HD AH
<input type="checkbox"/> 24 – Mental Health Service Provider (attach a copy of the Certificate of Accreditation)	→	HD AH
Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures and forms		
<input type="checkbox"/> Crisis Intervention		
<input type="checkbox"/> 102 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # _____)	→	MFP
<input type="checkbox"/> 103 – ICF/ID (enter your Medicaid Provider # _____)	→	MFP
<input type="checkbox"/> 104 – An agency with a contract to provide crisis intervention services with the Department of Human Services (provide documentation)	→	MFP

<input type="checkbox"/> Day Habilitation (DH)		
<input type="checkbox"/> 73 – Be accredited by the Council on Quality and Leadership (attach current certification and most recent survey report)	→	ID
<input type="checkbox"/> 74 – Be accredited by the Commission on Accreditation of Rehabilitation Facilities for similar services* (attach current CARF certification and most recent CARF survey report)	→	ID
<input type="checkbox"/> 75 – Be accredited by the Commission on Accreditation of Rehabilitation Facilities, but not for similar services*, until next regularly scheduled accreditation at which time the applicant will present documentation to the department that the similar service* requirement is met. HCBS waiver approval will be granted through the expiration date of the current CARF certification (attach current CARF certification and most recent CARF survey report)	→	ID
<input type="checkbox"/> 76 – Previous application for CARF accreditation. Conditional HCBS waiver approval will be granted for a maximum of 12 months from the date of CARF application (Submit a copy of the CARF application. You will be contacted in regards to submitting policies and procedures applicable to day habilitation.)	→	ID
<input type="checkbox"/> 77 – Previous application for Council on Quality and Leadership accreditation. Conditional HCBS waiver approval will be granted for a maximum of 12 months from the date of Council application (Submit a copy of the Council application.)	→	ID
<p>Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures and forms</p> <p>*Similar services include Personal and Social services, Community Integration services, Community Based Rehabilitation.</p>		
<input type="checkbox"/> Environmental Modifications, Adaptive Devices and Therapeutic Resources		
<input type="checkbox"/> 15 – Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	→	CMH
<input type="checkbox"/> 30 – A provider enrolled under the HCBS Children's Mental Health waiver as a Family and Community Support Services provider	→	CMH
<input type="checkbox"/> 45 – A provider enrolled as a waiver Home/Vehicle Modifications provider (no supporting documentation required)	→	CMH
<input type="checkbox"/> 39 – Community Business (attach current proof of liability and workers compensation coverage)	→	CMH
<input type="checkbox"/> 40 – Retail and wholesale businesses participating as providers in the Medicaid program (enter your Medicaid Provider # _____)	→	CMH
<input type="checkbox"/> Family and Community Supports (FCSS)		
<input type="checkbox"/> 22 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation _____)	→	CMH
<input type="checkbox"/> 84 – Behavioral Health Intervention providers qualified under 441-77.12(249A)	→	CMH
Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures and forms		
<input type="checkbox"/> Family Counseling (FC)		
<input type="checkbox"/> 22 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation _____)	→	BI
<input type="checkbox"/> 23 – Hospice (attach a copy of the license or enter your Certificate of License or Medicare Provider# _____)	→	BI
<input type="checkbox"/> 24 – Mental Health Service Provider (attach a copy of the Certificate of Accreditation)	→	BI
<input type="checkbox"/> 48 – Individuals who meet the definition of qualified brain injury professionals as designated in 441 IAC 83.81(249A)	→	BI
<input type="checkbox"/> 33 – Agencies certified as brain injury waiver providers pursuant to rule 441-77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441-83.81(294A)	→	BI
Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures and forms		

<input type="checkbox"/> Financial Management Services (FMS)		
<input type="checkbox"/> 91 – A credit union that is a cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa Department of Commerce (Attach documentation from NCUA or IDC). The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee	→	HD AH E ID BI PD
<input type="checkbox"/> 92 – A financial institution chartered by the office of the Comptroller of the Currency, a Bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC). The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.	→	HD AH E ID BI PD
<input type="checkbox"/> Home Delivered Meals (HDM)		
<input type="checkbox"/> 61 – Area Agency on Aging as designated in IAC 17 4.4(231) (no supporting documentation required)	→	HD AH E
<input type="checkbox"/> 59 – Subcontract with area agency on aging (attach a copy of the subcontract)	→	HD AH E
<input type="checkbox"/> 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	HD AH E
<input type="checkbox"/> 09 – Agencies authorized to provide similar services through a contract with the Department of Public Health (IDPH) for public health services (enter your contract #_____)	→	HD AH E
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→	HD AH E
<input type="checkbox"/> 26 – Hospital (enter your Medicare Provider # _____)	→	HD AH E
<input type="checkbox"/> 06 – Medical equipment and supply dealers (enter your Medicaid Provider # _____)	→	HD AH E
<input type="checkbox"/> 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	HD AH E
<input type="checkbox"/> 27 – Restaurant licensed and inspected under Iowa Code chapter 135F (attach a copy of the license)	→	HD AH E
<input type="checkbox"/> Home Health Aide (HHA)		
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→	HD AH E ID
<input type="checkbox"/> Homemaker (HM)		
<input type="checkbox"/> 09 – Agencies authorized to provide similar services through a contract with the Department of Public Health (IDPH) for public health services (enter your contract #_____)	→	HD AH E
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→	HD AH E
<input type="checkbox"/> Home Modifications (HM) <input type="checkbox"/> Vehicle Modifications (VM)		
<input type="checkbox"/> 61 – Area Agency on Aging as designated in IAC 17 4.4(231) (no supporting documentation required)	→	HD E
<input type="checkbox"/> 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	HD E
<input type="checkbox"/> 15 – Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	→	ID
<input type="checkbox"/> 45 – Provider enrolled as a waiver Home/Vehicle Modifications provider under another waiver (no supporting documentation required)	→	HD AH E BI PD
<input type="checkbox"/> 39 – Community Business (attach current proof of liability and workers compensation coverage)	→	HD AH E BI PD
<input type="checkbox"/> In-Home Family Therapy (IHFT)		
<input type="checkbox"/> 22 – Community Mental Health Center (attach a copy of the certificate or enter your Medicaid Provider # or Certificate of Accreditation _____)	→	CMH
<input type="checkbox"/> 41 – Mental Health professionals licensed pursuant to 645-Chapter 31, 240, or 280 or possessing an equivalent license in another state	→	CMH
Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures and forms		

<input type="checkbox"/> Interim Medical Monitoring & Treatment (IMMT)			
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→	HD	ID BI
<input type="checkbox"/> 15 – Provider enrolled under HCBS ID or BI Supported Community Living (no supporting documentation required)	→	HD	ID BI
Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures and forms			
<input type="checkbox"/> Mental Health Outreach (MHO)			
<input type="checkbox"/> 22 – Community Mental Health Center (attach a copy of the certificate of accreditation)	→	E	MFP
<input type="checkbox"/> 94 – A licensed psychologist or psychiatrist (attach a copy of the license)	→		MFP
<input type="checkbox"/> 95 – A behavioral analyst certified by the Behavior Analyst Certification Board (attach certification)	→		MFP
<input type="checkbox"/> 96 – A licensed mental health counselor (attach a copy of the license)	→		MFP
<input type="checkbox"/> 97 – A licensed social worker (attach a copy of the license)	→		MFP
<input type="checkbox"/> 98 – A licensed advanced registered nurse registered as certified in psychiatric mental health (attach license and certification)	→		MFP
Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures and forms			
<input type="checkbox"/> Nurse Delegation (ND)			
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→		MFP
<input type="checkbox"/> 106 – A nurse licensed by the Iowa Nursing Board as a registered or license practical nurse pursuant to IAC 655 (attach a copy of the license)	→		MFP
<input type="checkbox"/> Nursing (N)			
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→	HD AH E	ID
<input type="checkbox"/> Nutritional Counseling (NC)			
<input type="checkbox"/> 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	HD	E
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→	HD	E
<input type="checkbox"/> 26 – Hospital (enter your Medicare Provider # _____)	→	HD	E
<input type="checkbox"/> 28 – Licensed dietitian approved by an area agency on aging (attach a copy of the license and the letter from an area agency on aging)	→	HD	E
<input type="checkbox"/> 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	HD	E
<input type="checkbox"/> Personal Emergency Response (PERS)			
<input type="checkbox"/> 25 – Send information pamphlet	→	HD	E ID BI PD
<input type="checkbox"/> Prevocational Services (Prevoc)			
<input type="checkbox"/> 49 – Meet Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers (attach current certificate and most recent survey report)	→		BI
<input type="checkbox"/> 69 – Be accredited by the Commission on Accreditation of Rehabilitation Facilities under standards for work adjustment service providers or organizational employment service providers (attach current certificate and most recent survey report)	→		ID
<input type="checkbox"/> 73 – Be accredited by the Council on Quality and Leadership (attach current certification and most recent survey report)	→		ID
Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures and forms			

<input type="checkbox"/> Respite						
<input type="checkbox"/> 46 – Enrollment criteria met upon IME approval of policies, procedures and forms	→		ID	BI	CMH	
<input type="checkbox"/> 29 – Provider certified under HCBS ID Respite (no supporting documentation required)	→	HD	AH	E	BI	CMH
<input type="checkbox"/> 79 – Provider certified under HCBS BI Respite (no supporting documentation required)	→	HD	AH			CMH
<input type="checkbox"/> 08 – Home Health Agency (enter your Medicare Provider # _____)	→	HD	AH	E	ID	BI
<input type="checkbox"/> 09 – Agencies authorized to provide similar services through a contract with the Department of Public Health (IDPH) for public health services (enter your contract # _____)	→				ID	CMH
<input type="checkbox"/> 26 – Hospital (enter your Medicare Provider # _____)	→	HD	AH	E	ID	BI
<input type="checkbox"/> 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	HD	AH	E	ID	BI
<input type="checkbox"/> 35 – ICF/ID (enter your Medicaid Provider # _____)	→	HD	AH		ID	BI
<input type="checkbox"/> 44 – Licensed group living foster care facility (attach a copy of the license)	→	HD	AH		ID	BI
<input type="checkbox"/> 32 – Camps certified by the American Camping Association (attach a copy of the certificate)	→	HD	AH	E	ID	BI
<input type="checkbox"/> 30 – Provider with a certificate for Adult Day Care services issued by the Department of Inspections and Appeals confirming that the applicant is in compliance with the standards for adult day services programs adopted by the Department on Aging (attach a copy of the certificate)	→	HD	AH	E	ID	BI
<input type="checkbox"/> 50 – Residential care facility for persons with mental retardation licensed by DIA (attach a copy of the license)	→	HD			ID	BI
<input type="checkbox"/> 78 – Assisted Living Program certified by the Department of Inspections and Appeals as designated in IAC 481-69	→	HD	AH	E	ID	BI
Requires submission of a complete Provider Quality Management Self-Assessment						
<input type="checkbox"/> Senior Companion (SC)						
<input type="checkbox"/> 37 – Designation by Corporation for National and Community Service (attach documentation substantiating the designation)	→		E			
<input type="checkbox"/> Specialized Medical Equipment (SME)						
<input type="checkbox"/> 06 – Medical equipment and supply dealers (enter your Medicaid Provider # _____)	→				BI	PD
<input type="checkbox"/> 40 – Retail and wholesale businesses participating as providers in the Medicaid program (enter your Medicaid Provider # _____)	→				BI	PD
<input type="checkbox"/> Supported Community Living (SCL)						
<input type="checkbox"/> 46 – Enrollment criteria met upon IME approval of policies, procedures and forms	→			ID	BI	
<input type="checkbox"/> 53 – Provider enrolled under HCBS ID SCL (no supporting documentation required)	→				BI	
<input type="checkbox"/> 54 – Provider enrolled under HCBS BI SCL (no supporting documentation required)	→			ID		
Requires submission of a complete Provider Quality Management Self-Assessment						
<input type="checkbox"/> Residential-Based Supported Community Living (RBSCL)						
<input type="checkbox"/> 65 – Group Living Foster Care Facility (submit copy of group living foster care licensure under IAC 441-114 and a plan to come into compliance with IAC 441 77.37(23)"e"(3))	→			ID		
<input type="checkbox"/> 66 – Residential Facility for Mentally Retarded Children (submit copy of Residential Facility for Mentally Retarded Children under IAC 441-116 licensure and a plan to come into compliance with IAC 441 77.37(23)"e"(3))	→			ID		
Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures and forms						

<input type="checkbox"/> Supported Employment (SE)		
<input type="checkbox"/> 31 – An agency that is accredited by the commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service (attach copy of the certificate of accreditation)	→	ID BI
<input type="checkbox"/> 34 – An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services (attach copy of the certificate of accreditation)	→	ID BI
<input type="checkbox"/> 36 – An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services (attach copy of the certificate of accreditation)	→	ID BI
<input type="checkbox"/> 42 – An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services (attach copy of the certificate of accreditation)	→	ID BI
<input type="checkbox"/> 43 – An agency that is accredited by the International Center for Clubhouse Development (attach copy of the certificate of accreditation)	→	ID BI
Requires submission of a complete Provider Quality Management Self-Assessment and must submit policies, procedures and forms		
<input type="checkbox"/> Transportation (Trans)		
<input type="checkbox"/> 38 – Regional Transit Agency recognized by Iowa Department of Transportation (no supporting documentation required)	→	E ID BI PD
<input type="checkbox"/> 61 – Area Agency on Aging as designated in IAC 17-4.4(231) (no supporting documentation required)	→	E ID BI PD
<input type="checkbox"/> 59 – Subcontract with Area Agency on Aging (attach a copy of the subcontract)	→	E ID BI PD
<input type="checkbox"/> 07 – Community Action Agency as designated in IAC 216A.93 (no supporting documentation required)	→	E ID BI PD
<input type="checkbox"/> 10 – Nursing Facility Licensed under 135C Code of Iowa (no supporting documentation required)	→	E ID BI PD
<input type="checkbox"/> 109 – Transportation providers contracting with the nonemergency medical transportation contractor (attach NEMT welcome letter or contract)	→	E ID BI PD
<input type="checkbox"/> 72 – Contract with county government (attach a copy of the contract)	→	ID
<input type="checkbox"/> 111 – Provider with purchase of service contracts to provide transportation pursuant to 441 Chapter 150	→	BI
<input type="checkbox"/> 71 – Accredited provider of home- and community-based services	→	ID

<p>STATEMENT MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION IN, OR RELATED TO, THIS APPLICATION MAY BE PUNISHABLE BY CRIMINAL, CIVIL (INCLUDING A FALSE CLAIMS LAWSUIT) AND/OR ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.</p>									
<p>CERTIFICATION I HEREBY CERTIFY that I have read the above statement, and that I have examined this application and all accompanying documents, and that to the best of my knowledge and belief, each is true, correct, and complete. I further certify that I am familiar with the laws and regulations governing the medical assistance program (Iowa Medicaid) and that I am duly qualified to participate as a provider in that program. I PROMISE to apprise Iowa Medicaid immediately of any material changes to this application and provide true, correct, and complete answers to any subsequent questions of me by Iowa Medicaid related to or arising out of this application.</p>									
25. Signature of Authorized Official									
26. Date			/			/			
27. Contact Person									